Dominican Republic
Medical Information and Form

Part I: CONDITIONS SPECIFIC TO THE DOMINICAN REPUBLIC PROGRAM

Traveling to a different environment may pose emotional and physical challenges. It is important that you provide us with as much information as possible so that we can prepare you for your overseas program and assist you with any accommodations. The information provided in this form will not be used to exclude you from the program unless it has been determined that your participation poses a significant risk of substantial harm to yourself or others. The information is for use in the event of an emergency or other health matter. The information provided will remain confidential.

This form must be completed by you or by a parent/guardian if you are not legal age. You must return this form to the Volunteer Coordinator, PRHDR by the due date or you will not be able to participate in the program.

The Dominican Republic Health Outreach Program is made up of volunteers, faculty and students. Your spouse, partner, children, parents and others who care about you need to understand that it is not a vacation. Please share the conditions with them. Hundreds of people have done it safely, but we have had every type of health outcome including a fatal accident, so we know that the possibilities are not hypothetical. Other volunteers may be your best source of medical assistance in the DR, and the faculty reserves the right not to include you if they feel that you will not be reasonably safe.

Please assure PRHDR that you understand all the following conditions of participation. People with mild mobility problems can be transported to clinics by truck, however many people do walk to some clinics. Some days are long and it can be very rainy. Be prepared to do some walking in the rain. Your transport to mountain villages daily is in rented or local vehicles over hilly dirt roads. You are required to get extra vaccines at your own expense. You may be exposed to many tropical and contagious diseases and are responsible for your own follow-up care and treatment. In the past few years there have been upgrades in the healthcare system in the DR. For instance, there is now a new 911 system, with ambulances and fire trucks. However, we are in a rural area which is not served by that system, so in an emergency, we would be transporting by our own truck, with one of our medical providers in attendance. Most people, even in the rural areas have cell phones, but reception can be quite spotty, due to the mountainous terrain. There is a very modern and well equipped hospital in Santiago, about 45 minutes away.

Simple housing in a rural religious retreat includes triple bunkrooms with running water (NOT potable), toilet and shower room with door, and mosquito nets on bunk beds. Safe drinking water is purchased in large bottles and is the only water used for drinking. You must bring and carry a personal refillable water bottle at all times. Food is cooked daily on site by local staff. Vegetarians can eat a variety of appropriate food. "Traveler's diarrhea" and upper respiratory infections are common. Smoking and alcohol use should be extremely limited, especially in our home and partnership communities. Marijuana and other substances are illegal and use is cause for dismissal without course completion.

This list is not exhaustive; there may be other unforeseen risks. You must consider these conditions before committing to the program.

Permission to share information

I, _____, grant the faculty members leading this program and health providers permission to view all parts of this Medical Form and discuss any concerns with me.

Signature _____ Date _____

Name Printed _____

Return the completed medical form to:
Mary Berg, Volunteer Coordinator, PRHDR, PO Box 1742, Portland, ME 04104

Or email: marypt114@gmail.com

MEDICAL FORM TO BE COMPLETED BY THE VOLUNTEER – Part 1

1. Name _____ Program _____

Birth Date _____/_____/_____ Sex ____ Height ____ Weight _____ Blood Type (if known) _____

2. Home Address: _____

You reside with: ___ parent ___ spouse _____ Other _____

Emergency Contact #1(First contact)
Name _____ Relationship to You _____
Home Address _____City _____
State____ Zip_____ Best Phone(s)_____ E-mail_____

Emergency Contact #2 (Second contact)
Name _____ Relationship to You _____
Home Address _____City _____
State____ Zip_____ Best Phone(s)_____ E-mail_____

3. Do you have any known allergies to medications or vaccines? ❑ **Yes** ❑ **No** If yes, please explain.
_____
_____

4. Will you receive all vaccines recommended by USM and the CDC one month prior to your overseas program?
❑ **Yes** ❑ **No** If no, please explain. _____

5. Do you have any food allergies or dietary restrictions? ❑ **Yes** ❑ **No** If yes, please explain. _____
_____
6. Do you carry an epi-pen and/or medicines? ❑ **Yes** ❑ **No** If yes, please explain. _____
_____

7. **Check** all of the following conditions you have had or currently experience.

____ Anemia
____Arthritis or Immobility
____ Asthma
____ Blood Clotting Disorder
____ Cancer
____ **Cardiac condition**
____ Diabetes
____ **Epilepsy/Seizures**
____ Fainting/Blackouts
____ GI disorder
____ Hearing Impairment
____ Immune System Problem/ Immunosuppressant treatment
____ Kidney Disease
____ Latex Allergy
____ Lung condition
____ Mental Health Condition: (Anxiety, Panic attacks, depression, bipolar disorder, ADHD, Substance dependency, other_____)
____ Skin (eczema, psoriasis)
____Other _____

❑ I have reviewed the list above and none of the conditions does or did apply to me.
Give diagnosis and explain any recent or serious health episodes (use additional paper if necessary).
_____

8. Last intradermal tuberculin test (PPD) or X-ray (must be within one year of departure).
Date: _____ Results _____Where it was completed _____

TO BE COMPLETED BY PRIMARY CARE MEDICAL PROVIDER – Part 2

1. Is the information provided by the above volunteer in Part I complete and correct to the best of your knowledge?
   ❑ **Yes** ❑ **No** If no, please explain.

_____
_____

2. Is the Volunteer currently on medication or receiving medical treatment? ❑ **Yes** ❑ **No** If yes, please explain.

_____
_____

3. Will the student continue medication while abroad? ❑ **Yes** ❑ **No**
4. Has the student had any recent medical conditions or surgeries that could require attention while traveling abroad?
❑ **Yes** ❑ **No**

Please note any other information, including details of current treatment, which could be helpful to a physician treating this student while overseas (use additional paper if necessary). Take into account the risks described in the introduction.

_____
_____
_____
_____
_____

5. Does this student have any ongoing physical or emotional condition, disability, or impairment that poses a significant risk of substantial harm to themselves or others? Please take into account the risks described in the introduction.
❑ **Yes** ❑ **No** If yes, please elaborate.

_____
_____
_____

6. Date of last examination (*within the last 12 months).* _____

Signature _____Date_____

❑ Physician/ Nurse Practitioner/or Physician Assistant's name (print) _____

Address _____ City _____ State ___ Zip _____
Phone number: _____, Ext: _____

TO BE COMPETED BY VOLUNTEER – Part 3

Permission for emergency treatment

In the event I am unable to make rational decisions regarding my medical care and my emergency contacts cannot be reached, or if the delay may cause serious danger to me, I authorize medical and/or surgical treatment as may be deemed necessary or advisable for me (or my child). I also authorize the release of medical information to insurance companies for the purpose of payment, and to health care providers who may treat me (or my child).

Signature _____ Date _____